BOARD OF SUPERVISORS MEETING
December 10, 2019

"For all items *NOT* on the agenda"

(Each Speaker Limited to 3 Minutes)

Voluntary Sign-In Sheet

1. Vernon Price
2. Paul Nicholson — PGE Communications
3. Jim Mark Scotty
4. Tom Stokely
5. ~~Al Forsythe~~
6. Thomas Mulder - Stock Piles
7. Barbara Rohr
8. Isaac
9. DAVE CORDICES
10. Michael McKaskle
11. Sen McGuire
12. McKaskle
13.
14.
15.
16.

CAL VOICES ADVOCACY · RECOVERY · PEER SUPPORT a continuation of NorCal MHA Mental Health America
ACCESS California A PROGRAM OF CAL VOICES
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December 6, 2019

The Honorable Dr. Joaquin Arambula and Assembly Budget Subcommittee Members
CA Budget Subcommittee No. 1 on Health & Human Services
Capitol Building
Sacramento, CA 95814

RE: December 9, 2019 Committee Hearing on The Promise of Prop 63 and the Future of Mental Health Funding in CA

Dear Chair Arambula and Budget Subcommittee No. 1 Members,

Cal Voices (formerly Mental Health America of Northern California) is the oldest peer run mental health advocacy organization in California. With over 60 peer staff and numerous statewide programs, including our ACCESS California statewide consumer advocacy program funded by the Mental Health Services Oversight and Accountability Commission (MHSOAC), Cal Voices is the leading representative of the consumer voice in California. On behalf of the clients and consumers across California that Cal Voices represents, we write you to express a brief summary of our views on the Mental Health Services Act (MHSA/Prop 63).

Cal Voices, ACCESS California, and the Clients/Consumers we represent firmly believe that:

1. **The MHSA does not need to be changed or "refreshed," it needs to be properly enforced;**
2. **With DHCS considering significant changes to the Medi-Cal program through its CalAIM initiative, now is NOT the time to be simultaneously altering the MHSA; and**
3. **Clients/Consumers must be treated as essential partners in all policy planning and discussions regarding proposed changes to the MHSA.**

THE MHSA SHOULD BE ENFORCED, NOT "REFRESHED"

The MHSA, as currently written, continues to hold the promise of dramatically improving mental health care in California by funding highly effective, recovery-oriented and client driven services. It does not need to be rewritten or "refreshed", it simply needs to be enforced. We have heard California's recently-appointed Special Advisor to Mental Health comment on the need for:

- Statewide performance/outcome metrics

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- A focus on people who are homeless or at risk of homelessness
- Statewide guidance on priorities for the MHSA, and
- Regional approaches for county collaboration

All of these elements are already included in the MHSA (see attachment for specific Code Sections), but are not being enforced.[1] Californians voted for Prop 63, in part, because it promised to "expand a program that works,"[2] namely, those integrated mental health, housing, substance use disorder, and social services for homeless adults living with severe mental illness funded through AB 34 (Steinberg, 1999) and AB 2034 (Steinberg, 2000) demonstration grants. While a 2003 report to the CA legislature on AB 34/AB 2034 outcomes demonstrated these programs were highly effective in reducing homelessness, incarceration, and hospitalization days for adults with mental illness and were expected to net overall savings for the State,[3] ongoing funding for these programs relied on allocations from the State's general fund. Prop 63 was introduced to secure a dedicated funding source for the continuation and expansion of the successful demonstration projects developed through AB 34/AB 2034.

Prop 63's authors also ensured voters there would be "strict accountability for [MHSA] funds," because "[a]n oversight panel of independent, unpaid members supervises expenditures ... [and] can cut off funding for programs that are not effective."[4] **Because of the inherent difficulty in implementing large system transformation, this promised enforcement was an indispensable element, critical to the Act's success.**

Unfortunately, enforcement of the MHSA has steadily declined since its passage. Many enforcement mechanisms were simply eliminated with the passage of AB 100 in 2011, including State review and approval of counties' MHSA three-year program and expenditure plans and preapproval of county prevention plans. Further deterioration of enforcement came with the passage of AB 1467 and the resulting dismantling of the California Department of Mental Health (DMH) in 2012 and the concurrent elimination of the State's duty to establish requirements for county three-year plans.

Since the Department of Health Care Services (DHCS) inherited DMH's MHSA oversight and enforcement responsibilities, it has done little to ensure county compliance with the Act. In 2016, the Little Hoover Commission (Commission) found DHCS's oversight of MHSA programs was minimal, and that **"[DHCS] does not analyze the data reported in [counties' annual MHSA] reports to determine whether counties spent the funds as they proposed**,"[5] even after the Commission had already notified DHCS of these same deficiencies in the Commission's 2015 evaluation of MHSA oversight and outcomes. The Commission concluded in 2016:

> It is clearer than ever in the wake of the Commission's second review that **the state must identify a well-defined leader to administer, oversee and enforce the MHSA or it will remain difficult to articulate a cohesive vision for the Act and ensure accountability to alleviate many of the visible statewide impacts of mental illness**.[6]

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In both 2013 and 2018, the California State Auditor (Auditor) reported similar concerns regarding statewide oversight agencies' enforcement of the MHSA. In 2013, the Auditor found that DMH and the MHSOAC "have provided little oversight of counties' implementation of MHSA programs, particularly as it relates to evaluating whether these programs are effective," and that DMH had never "provide[d] explicit direction to the counties on how to evaluate their [MHSA] programs effectively, including directions for setting reasonable goals, establishing specific objectives, and gathering the data necessary to meaningfully measure program performance."[7]

In 2018, the Auditor noted that "[d]espite having significant responsibility for the MHSA program since 2012, [DHCS] has allowed local mental health agencies to amass hundreds of millions in unspent MHSA funds," which counties "could better use to provide additional mental health services."[8] Most troubling was the Auditor's conclusion that:

> **[DHCS'] oversight of local mental health agencies is minimal: it does not enforce annual revenue and expenditure reporting nor has it performed fiscal or program audits to ensure local mental health agencies comply with fiscal and program requirements contained in state laws and regulations.**[9]

There is no mystery why, despite the MHSA's promise and intent, the State continues to struggle with high rates of homelessness, incarceration, and substance use amongst its citizens with mental illness, and its public mental health services remain inadequate for those most in need. When voters wonder why the MHSA has failed to deliver on its promises, the legislature need look no further than the agency charged with the Act's enforcement. The Special Advisor for Mental Health envisions what the MHSA already provides, if only the Act were properly enforced.

THE POTENTIAL IMPACTS OF DHCS' CalAIM INITIATIVE ON THE MHSA ARE UNKNOWN

Second, the MHSA, with its strong nonsupplantation provisions, was intended to fill gaps in services, and to provide services beyond those already provided by Medi-Cal entitlement programs. DHCS has recently released its CalAIM proposal to overhaul Medi-Cal with the goal to:

> [H]elp address many of the complex challenges facing California's most vulnerable residents, such as **homelessness**, **insufficient behavioral health care access**, **children** with complex medical conditions, the growing number of **justice-involved populations** who have significant clinical needs, and the growing **aging** population.[10]

DHCS' CalAIM proposal published on October 28, 2019, acknowledges the agency has not considered the potential impacts that overhauling the entire Medi-Cal system may have on non Medi-Cal mental health programs and/or programs that rely on blended funding streams, including those funded by the MHSA:

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> DHCS will seek stakeholder feedback on the following questions in order to explore ideas around Full Integration Plans: [...] What impact would a fully integrated Medi-Cal delivery system have on non-Medi-Cal program mandates (e.g., Mental Health Services Act, SAMHSA block grants)?[11]

First, this is the only direct reference to the MHSA in the entire CalAIM proposal, although the MHSA provides approximately 20% of all county behavioral health funding[12] and "counties apply an unknown portion of MHSA funds toward their local match for federal funds for Medi-Cal."[13]

Second, DHCS has not adequately engaged consumer stakeholders in these discussions. The CalAIM committee DHCS convened includes no individuals who identify as current or former public mental health consumers, and no participants from consumer advocacy programs or organizations to weigh in on these important matters.

CalAIM will ultimately create fundamental changes to California's public mental health system, with a focus on the same populations that the MHSA refresh intends to target. Any changes made to the MHSA must be made after DHCS' changes are implemented so that local service gaps/needs can be identified, and MHSA programs subsequently created to fill those gaps.

THE STATE MUST HONOR THE ROLE OF CONSUMERS UNDER THE MHSA AS THE PRIMARY DRIVERS OF ALL MENTAL HEALTH POLICY

Lastly, the MHSA requires counties to "demonstrate a partnership with constituents and stakeholders throughout the [MHSA] process that includes **meaningful stakeholder involvement** on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations." (WIC § 5848(a).) Counties must utilize a portion of their annual MHSA revenues "to pay for the costs of consumers, family members, and other stakeholders to participate in the [MHSA] planning process," whereby counties develop their MHSA three-year program and expenditure plans and annual updates. (WIC § 5892(c).)

Statewide agencies receiving MHSA administrative funding (including DHCS, MHSOAC, and the Behavioral Health Planning Council) must set aside a portion of these funds "to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services." (WIC § 5892(d).)

Accordingly, the MHSA requires **authentic and significant consumer participation** in all aspects of mental health planning and policy development. Counties and statewide agencies are mandated by law to include consumers in these discussions. Yet because the MHSA is not adequately enforced, consumers remain overlooked and are continuously left out of these vital conversations. Consumers' real concerns about the effectiveness and adequacy of MHSA-funded services are frequently ignored or disregarded.

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The Little Hoover Commission acknowledged as much its 2016 follow up report on statewide MHSA oversight, noting:

> **The Commission heard repeatedly from stakeholders desperate for more oversight of the Act and concerned about the lack of consequences for bad behavior.** Many said the processes to oversee the distribution and use of MHSA funds at the local and state levels are still woefully inadequate and leave those with questions or concerns confused about where to get answers.[14]

The Commission further remarked that a statewide oversight agency is needed to "**take charge to ensure counties are appropriately engaging stakeholders,**"[15] and that:

> **State mental health leaders, with relevant stakeholders, should collectively identify indicators that will show progress toward reducing the negative outcomes from untreated mental illness. Defined by the Act, those include suicide, incarcerations, school failure or dropping out rate, unemployment, prolonged suffering, homelessness, and removal of children from their homes.**[16]

We ask that the legislature do its part to include consumers and other stakeholders in any discussions regarding proposed updates, changes, or revisions to the MHSA by continuing to invite us to the table, seeking our guidance and feedback, and refusing to in any way amend the MHSA without the genuine participation of those who will be greatest affected.

Thank you for your time and consideration.

Sincerely,

Susan Gallagher, MMPA
Executive Director, Cal Voices

Dawniell A. Zavala, Esq.
Associate Director/General Counsel, Cal Voices

Karen Vicari, JD
Director of Policy, Cal Voices/ACCESS California

Noah Hampton-Asmus
Legislative Policy Analyst, Cal Voices/ACCESS California

Andrea Crook, NCPS
Director of Advocacy, Cal Voices/ACCESS California

Tiffany Carter, MS
Statewide Advocacy Liaison, Cal Voices/ACCESS California

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Attachment 1

WIC §	Text of Code Section	Elements of the MHSA "refresh" addressed
§5813.5(f)	(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison or parolees from state prisons.	• Target population
§5840(a),(c),(f)	(a) The State Department of Health Care Services, in coordination with counties, shall establish a program designed to prevent mental illnesses from becoming severe and disabling. The program shall emphasize improving timely access to services for underserved populations. (c) The [three-year] plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) funded by the Mental Health Services Fund and ***established jointly by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, in collaboration with the County Behavioral Health Directors Association of California***. (f) In consultation with mental health stakeholders, and consistent with regulations from the Mental Health Services Oversight and Accountability Commission, pursuant to Section 5846 , **the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for children, adults, and seniors.**	• Regional Approaches • More standardization across the state/Statewide goals • Focus on outcomes • Stronger oversight of Counties
§5845(d)(7)	In carrying out its duties and responsibilities, the commission may do all of the following: (7) Participate in the joint state-county decisionmaking process, as contained in Section 4061 , **for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system.**	• Regional Approaches • More standardization across the state/Statewide goals • Focus on outcomes • Stronger oversight of Counties
§4061(a)(1-4)	(a) The State Department of Health Care Services shall utilize a joint state-county decisionmaking process to determine the appropriate use of state and local training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health and substance use disorder services system. The department shall use the decisionmaking collaborative process required by this section in all of the following areas: (1) Providing **technical assistance** to personnel of the State Department of Health Care Services and local behavioral health, mental health, and substance use disorder services departments through direction of existing state and local mental health and substance use disorder services staff and other resources. (2) **Analyzing mental health and substance use disorder programs, policies, and procedures.**	• Regional Approaches • More standardization across the state/Statewide goals • Focus on outcomes • Stronger oversight of Counties

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	(3) Providing forums on specific topics as they relate to the following: **(A) Identifying current level of services.** **(B) Evaluating existing needs and gaps in current services.** **(C) Developing strategies for achieving statewide goals and objectives in the provision of services for the specific area.** **(D) Developing plans to accomplish the identified goals and objectives.** **(4) Providing forums on policy development and direction with respect to mental health and substance use disorder program operations and clinical issues.**	
§5845(d)(10-12)	In carrying out its duties and responsibilities, the commission may do all of the following: (10) **If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the State Department of Health Care Services pursuant to Section 5655**. (11) **Assist in providing technical assistance** to accomplish the purposes of the Mental Health Services Act, Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) in collaboration with the State Department of Health Care Services and in consultation with the County Behavioral Health Directors Association of California. (12) Work in collaboration with the State Department of Health Care Services and the California Behavioral Health Planning Council, and in consultation with the County Behavioral Health Directors Association of California, in **designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, including, but not limited to, parts listed in subdivision (a). The California Health and Human Services Agency shall lead this comprehensive joint plan effort.**	• Regional Approaches • More standardization across the state/Statewide goals • Focus on outcomes • Stronger oversight of Counties
§5846(a)(d)	(a) **The commission shall adopt regulations for programs and expenditures pursuant to Part 3.2 (commencing with Section 5830), for innovative programs, and Part 3.6 (commencing with Section 5840), for prevention and early intervention**. (d) The commission shall ensure that the perspective and participation of diverse community members reflective of California populations and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations.	• Regional Approaches • More standardization across the state/Statewide goals • Focus on outcomes
§5848(a)	(a) **Each three-year program and expenditure plan and update shall be developed with local stakeholders**, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation,	• Enforcing the CPP requirements eliminates ineffective programs

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	and budget allocations. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans.	
§5848(c)	(c) The **plans shall include reports on the achievement of performance outcomes for services** pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) funded by the Mental Health Services Fund and **established jointly by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, in collaboration with the County Behavioral Health Directors Association of California.**	• More standardization across the state/Statewide goals • Focus on outcomes
§5878.3	(a) Subject to the availability of funds as determined pursuant to Part 4.5 (commencing with Section 5890) of this division, county mental health programs shall offer services to severely mentally ill children for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable. Other entitlement programs include but are not limited to mental health services available pursuant to Medi-Cal, child welfare, and special education programs. The funding shall cover only those portions of care that cannot be paid for with public or private insurance, other mental health funds or other entitlement programs. (b) **Funding shall be at sufficient levels to ensure that counties can provide each child served all of the necessary services set forth in the applicable treatment plan** developed in accordance with this part, including services where appropriate and necessary to prevent an out of home placement, such as services pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9.	• Target Population
§5892(c)	(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of these costs shall not exceed 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850).	
§5897(a)	(a) Notwithstanding any other state law, **the State Department of Health Care Services shall implement the mental health services** provided by Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) **through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis.** For purposes of this section, a county mental health program includes a city receiving funds pursuant to Section 5701.5.	• Regional Approaches • More standardization across the state/Statewide goals • Focus on outcomes • Stronger oversight of Counties

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[1] https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/225/Report225.pdf and https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/233/Report233.pdf

[2] https://vig.cdn.sos.ca.gov/2004/general/english.pdf (p. 37)

[3] http://histpubmh.semel.ucla.edu/sites/default/files/archival/8a7e9bff_AB2034_may2003.pdf (Executive Summary, pp. i-ii)

[4] https://vig.cdn.sos.ca.gov/2004/general/english.pdf (p. 37)

[5] https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/233/Report233.pdf (p. 8)

[6] https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/233/Report233.pdf (p. 2)

[7] https://www.bsa.ca.gov/pdfs/reports/2012-122.pdf (Executive Summary, p. 1)

[8] https://www.auditor.ca.gov/pdfs/reports/2017-117.pdf (Executive Summary, p. 1)

[9] https://www.auditor.ca.gov/pdfs/reports/2017-117.pdf (Executive Summary, p. 1)

[10] https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM-Executive-Summary.pdf

[11] https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM_Proposal_102819.pdf (p. 54)

[12] https://www.cbhda.org/resources (funding infographic)

[13] https://lao.ca.gov/handouts/health/2019/Funding-Medi-Cal-Mental-Health-Services-022619.pdf (p. 5)

[14] https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/233/Report233.pdf (pp. 1-2)

[15] https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/233/Report233.pdf (p. 2)

[16] https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/233/Report233.pdf (p. 18)

December 8, 2019

TALKING POINTS FOR LETTER TO SENATOR MCGUIRE

Regarding funding radios for all essential school personnel

The Senator has proven he is a Champion for Children with Town Halls on ACE's, Adverse Childhood Experiences and many other causes he supports. It is obvious he places a high priority on all children. My idea to provide walkie-talkie radios to all teachers and essential personnel for proper communication during emergencies like a shooter, injury to a child or many other adverse experiences would drastically improve First Responders ability to assist during an event.

Proper and quick communication can help minimize the damage or injury caused by a shooter, fire or serious injury. It would drastically reduce the response time. Eureka Police, Humboldt County Sheriff and CHP all agree having proper communication is essential to achieve this. One teacher said supplying the first, First Responder a radio so he/she can communicate to all what the situation is would be a "game changer".

Shooters look for the most vulnerable locations like churches, malls, concerts and schools. The more panic they create, the better they like it. By supplying radios to the essential personnel at school, it may reduce the occurrences at schools because shooters will know their rampage will not go unabated for an extended period of time, like they can now.

Having the radios and a plan would also reduce the potential lawsuits that occur after a shooting. Schools have monthly fire drills and a "radio check" could be done at the same time. Students would know a plan is in place to help them during any event and would help alleviate the stress they feel during any adverse experience.

With the recent and future power outages, it became apparent that a backup form of communication is needed. With no power, video surveillance and intercoms do not work. Many cell phones also did not work. Using a cell phone allows one person to contact another person but radios can keep all people in contact at one time with no delay even if there is no power. With cell phones, you have to know each person's number in order to contact them. Taking time to look up and call creates a serious delay that could be avoided by radios.

This should be done Nationwide. The Senator can lead the way for the rest of the Country.

Please join me in contacting Senator Mike McGuire at the State Capitol. His address is 1303 10th Street, Room 5061, Sacramento, CA 95814. 916-651-4002. You can fax a letter to him at 916-651-4902.

Sincerely,

Paul Nicholson (A911 Guy)

911guypjn@gmail.com

PAUL NICHOLSON
Retired Insurance Agent

911 Simulator

Your child has been given the opportunity to make a 911 call from the 911 Simulator. The simulator was purchased so it could be used to teach young children how to make a 911 call. Below is a breakdown of what the teachers and I discussed with the students regarding a 911 call:

1. How to make a 911 call AND when to make a call.

2. We talked about the difference between a land line and cell phone call to 911, where a land line call should know your address and a cell phone call may not provide that information. We discussed an easy way to help identify where your child may be by providing the license plate of a vehicle at the home where they are located. I have given a refrigerator magnet to your child so you can write down information they may use if there is an emergency at your home.

3. We discussed what information they should know when making a call: first and last name, address, phone number and a description of the emergency.

4. I suggested your child ask you what you want done at your home if there is a fire or other emergency. They should know two ways out of their bedroom and two ways out of your home. If they do know this, they can hold up two fingers when the Fire Department drives by, which will make them smile. Please practice this often. A discussion like this will give your children the power and guidance to help themselves or someone else in an emergency.

5. IMPORTANT: Please show your child how to get past your lock screen to make an emergency call to 911 without knowing your code. Rehearse often so it will be easier to remember in an emergency. Also use the Health Medical ID App on the iPhone or get Medical ID ICE Contacts for Androids so 1st responders can access important medical information or your emergency contacts.

It is my hope that by showing the simulator to your son/daughter they may have learned something that will help them if there is an emergency. By using the simulator your child was given an idea of what to expect when calling 911, however this does not mean your child is proficient in making emergency calls.

I appreciate the opportunity the school gave to me to demonstrate how to properly call 911 and I hope you find my review of the presentation useful.

Sincerely,

Paul Nicholson

PLEASE VISIT MY WEBSITE - A911GUY.COM * AND ALSO * 911FORKIDS.COM